This 5/4/2007 draft is subject to change based on internal Department review and input from the regulated community.

TITLE 9. HEALTH SERVICES

CHAPTER 11. DEPARTMENT OF HEALTH SERVICES

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ARTICLE 1. ~~GENERAL~~ DEFINITIONS

R9-11-101. Definitions

~~A.~~ ~~"Accrual" means recording revenues and expenses when incurred with specific periods of time, such as a month or year, without regard to the date of receipt or payment of cash.~~

~~B.~~ ~~"Affiliated Organization" means the same as "related party."~~

~~C.~~ ~~"Annualized" means data for any period adjusted to represent a 12-month time period.~~

~~D.~~ ~~"Charge Code" means a numeric or alpha-numeric identifier assigned by the health care institution to a unit of service such as a procedure, test, or commodity for which a separate charge is levied to a patient and used for identification on a patient's itemized bill.~~

~~E.~~ ~~"Charity Allowances" means reductions in charges for services made by the health care institution because of the indigence of the patient. This does not include Title XIX Arizona Health Care Cost Containment Service (AHCCCS) or any other third- party payor settlements.~~

~~F.~~ ~~"Department" or "DHS" means the Department of Health Services.~~

~~G.~~ ~~"Direct costs" means those costs which are incurred by and charged directly to the revenue-producing departments of the institution.~~

~~H.~~ ~~"Director" means the Director of the Department.~~

~~I.~~ ~~"Durable Medical Equipment" means reusable equipment a health care institution makes available for patient services. The equipment can be sold, rented or furnished at no cost to a patient.~~

~~J.~~ ~~"Expendable" means those non-reusable commodities that may be sold to and are consumed by the patient.~~

~~K.~~ ~~"Formula" means a defined mathematical progression applied to the cost of a product to calculate a patient charge.~~

~~L.~~ ~~"Health care institution" or "institution" means every place, building or agency, whether organized for profit or not, which provides medical services, nursing services, or health-related services, except those institutions exempted by A.R.S. 36-402.~~

~~M.~~ ~~"Indirect costs" means those costs which are incurred by and charged directly to the non-revenue-producing departments and then are proportionately allocated to the revenue-producing departments of the institution.~~

~~N.~~ ~~"Inpatient hospice" means a hospice licensed by the Department pursuant to A.R.S. 36-405, 36-422 and A.A.C. Title 9, Chapter 10, Article 8 providing 24-hour inpatient care.~~

~~O.~~ ~~"Level of Care" means categorizing patient services according to the type of care provided by the health care institution. Patient care factors, such as nursing hours, physical assistance or~~

~~administration of medications, may be assigned numeric values generating accumulated or weighted points used to apply charges.~~

~~**P.** "Managed Care" means services delivered to clients through a health maintenance organization, preferred provider organization, third-party administrator or an independent physician association.~~

~~**Q.** "Material" means a significant change in revenue or expense in relation to total revenue or significant changes that affect how a facility is managed or controlled.~~

~~**R.** "Natural Classification" means the classification of expenses as reported on the income statement; i.e., the nature of the items as accrued, such as, salaries/wages, benefits, supplies, purchased services, insurance, and depreciation.~~

~~**S.** "Nonexpendable" means those reusable items that may be rented or sold to the patient. This may include durable medical equipment.~~

~~**T.** "Pass through" means any outside service or purchased commodity that is charged to a patient at the health care institution's cost.~~

~~**U.** "Private payor" means an individual or insurance company responsible for the payment of services. Third-party government payor programs are not considered private payors.~~

~~**V.** "Rate or Charge" means a separate dollar amount levied to a patient for use or consumption of a unit of service or commodity.~~

~~**W.** "Related Party" means an investor (individual, partner or corporation) having more than 5% ownership of another entity.~~

~~**X.** "Senior Plan" means contracted managed care services that are an alternate method of delivering services to Medicare-eligible clients.~~

~~**Y.** "Service" means a unit of care such as a procedure, test, or commodity for which a separate rate or charge is made to a patient.~~

In this Chapter, unless otherwise specified:

1. "Admission" or "admitted" means documented acceptance by a health care institution of an individual as an inpatient of a hospital, a resident of a nursing care institution, or a patient of a hospice.
2. "AHCCCS" means the Arizona Health Care Cost Containment System, established under A.R.S. § 36-2902.
3. "Allowance" means a charity care discount, self-pay discount, or contractual adjustment.
4. "Arizona facility ID" means a unique code assigned to a hospital by the Department to identify the source of inpatient discharge or emergency department discharge information.

5. "Attending provider" means the medical practitioner who has primary responsibility for the services a patient receives during an episode of care.
6. "Available bed" means an inpatient bed or resident bed, as defined in A.R.S. § 36-401, for which a hospital, nursing care institution, or hospice has health professionals and commodities to provide services to a patient or resident.
7. "Bill" means a statement for money owed to a health care institution for the provision of the health care institution's services.
8. "Business day" means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
9. "Calendar day" means any day of the week, including a Saturday or a Sunday.
10. "Cardiopulmonary resuscitation" means the same as in A.R.S. § 36-3251.
11. "Charge" means a specific dollar amount set by a health care institution for the use or consumption of a unit of service provided by the health care institution.
12. "Charge source" means the unit within a health care institution that provided services to an individual for which the individual's payer source is billed.
13. "Charity care" means services provided without charge to an individual who meets certain financial criteria established by a health care institution.
14. "Chief administrative officer" means the same as in A.A.C. R9-10-101.
15. "Chief financial officer" means an individual who is responsible for the financial records of a health care institution.
16. "Classification" means a designation that indicates the types of services a hospital provides.
17. "Clinical evaluation" means an examination performed by a medical practitioner on the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual.
18. "Commodity" means a non-reusable material, such as a syringe, bandage, or IV bag, utilized by a patient or resident.
19. "Contractual adjustment" means the difference between charges billed to a payer source and the amount that is paid to a health care institution based on an established agreement between the health care institution and the payer source.
20. "Control number" means a unique number assigned by a hospital for an individual's specific episode of care.

21. "Code" means a single number or letter, a set of numbers or letters, or a combination of numbers and letters that represents specific information.
22. "Department" means the Arizona Department of Health Services.
23. "Designee" means a person assigned by the governing authority of a health care institution or by an individual acting on behalf of the governing authority to gather information for or report information to the Department.
24. "Diagnosis" means the identification of a disease or injury, by an individual authorized by law to make the identification, that is a cause of an individual's current medical condition.
25. "Discharge" means a health care institution's termination of services to a patient or resident for a specific episode of care.
26. "Discharge status" means the disposition of a patient, including whether the patient was:
    a. Discharged home,
    b. Transferred to another health care institution, or
    c. Died.
27. "DNR" means Do Not Resuscitate, a document prepared for a patient indicating that cardiopulmonary resuscitation is not to be used in the event that the patient's heart stops beating.
28. "E-code" means an International Classification of Diseases code that is used:
    a. In conjunction with other International Classification of Diseases codes that identify the principal and secondary diagnoses for an individual; and
    b. To further designate the individual's injury or illness as being caused by events such as:
        i. An external cause of injury, such as a car accident;
        ii. A poisoning; or
        iii. An unexpected complication associated with treatment, such as an adverse reaction to a medication or a surgical error.
29. "Electronic" means the same as in A.R.S. § 36-301.
30. "Emergency" means the same as in A.A.C. R9-10-201.
31. "Emergency department" means the unit within a hospital that is designed for the provision of emergency services.
32. "Emergency services" means the same as in A.A.C. R9-10-201.
33. "Episode of care" means medical services, nursing services, or health-related services provided by a hospital to a patient for a specific period of time, ending with a discharge.

34. "Fiscal year" means a consecutive 12-month period established by a health care institution for accounting, planning, or tax purposes.
35. "Governing authority" means the same as in A.R.S. § 36-401.
36. "Health care institution" means the same as in A.R.S. § 36-401.
37. "Health-related services" means the same as in A.R.S. § 36-401.
38. "Home health agency" means the same as in A.R.S. § 36-151.
39. "Home health services" means the same as in A.R.S. § 36-151.
40. "Home office" means the person that is the owner of and controls the functioning of a nursing care institution.
41. "Hospice" means the same as in A.R.S. § 36-401.
42. "Hospital" means the same as in A.A.C. R9-10-201.
43. "Hospital administrator" means the same as "administrator" in A.A.C. R9-10-201.
44. "Hospital services" means the same as in A.A.C. R9-10-201.
45. "International Classification of Diseases Code" means a code included in a set of codes such as the ICD-9-CM or ICD-10-CM codes, which is used by a hospital for billing purposes.
46. "Inpatient" means the same as in A.A.C. R9-10-201.
47. "Licensed capacity" means the same as in A.R.S. § 36-401.
48. "Management company" means an entity that:
    a. Acts as an intermediary between the governing authority of a nursing care institution and the individuals who work in the nursing care institution,
    b. Takes direction from the governing authority of the nursing care institution, and
    c. Ensures that the directives of the governing authority of the nursing care institution are carried out.
49. "Medical practitioner" means an individual who is:
    a. Licensed:
        i. As a physician;
        ii. As a dentist, under A.R.S. Title 32, Chapter 11, Article 2;
        iii. As a podiatrist, under A.R.S. Title 32, Chapter 7;
        iv. As a registered nurse practitioner, under A.R.S. Title 32, Chapter 15;
        v. As a physician assistant, under A.R.S. Title 32, Chapter 25; or
        vi. To use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state; or

b. Licensed in another state and authorized by law to use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state.

50. "Medical record number" means a unique number assigned by a hospital to an individual for identification purposes.

51. "Medical services" means the same as in A.R.S. § 36-401.

52. "Medicare" means a federal health insurance program established under Title XVIII of the Social Security Act.

53. "National provider identifier" means the unique number assigned by the Centers for Medicare and Medicaid Services to a health care institution, physician, registered nurse practitioner, or other medical practitioner to submit claims and transmit electronic health information to all payer sources.

54. "Newborn" means a human:

a. Whose birth took place in the reporting hospital, or

b. Who was:

i. Born outside a hospital,

ii. Admitted to the reporting hospital within 24 hours of birth, and

iii. Admitted to the reporting hospital before being admitted to any other hospital.

55. "Nursing care institution" means the same as in A.R.S. § 36-446.

56. "Nursing care institution administrator" means the same as in A.R.S. § 36-446.

57. "Nursing services" means the same as in A.R.S. § 36-401.

58. "Patient" means the same as in A.A.C. R9-10-101.

59. "Payer source" means an individual or an entity, such as a private insurance company, AHCCCS, or Medicare, to which a health care institution sends a bill for the services provided to an individual by the health care institution.

60. "Physician" means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, as a doctor of naturopathic medicine under A.R.S. Title 32, Chapter 14, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.

61. "Principal diagnosis" means the reason established after a clinical evaluation of a patient to be chiefly responsible for a specific episode of care.

62. "Principal procedure" means the procedure judged by an individual working on behalf of a hospital to be:

a. The most significant procedure performed during an episode of care, or

b. The procedure most closely associated with a patient's principal diagnosis.

63. "Priority of visit" means the urgency with which a patient required medical services during an episode of care.

64. "Procedure" means a set of activities performed on a patient that:

a. Is intended to diagnose or treat a disease, illness, or injury;

b. Requires the individual performing the set of activities be trained in the set of activities; and

c. May be invasive in nature or involve a risk to the patient from the activities themselves or from anesthesia.

65. "Prospective payment system" means a system of classifying episodes of care for billing and reimbursement purposes, based on factors such as diagnoses, age, and sex.

66. "Refer" means to direct an individual to a health care institution for services provided by the health care institution.

67. "Referral source" means a code designating the entity that referred or transferred a patient to a hospital.

68. "Registered nurse practitioner" means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.

69. "Reporting period" means the specific fiscal year, calendar year, or portion of the fiscal or calendar year for which a health care institution is reporting data to the Department.

70. "Residence" means the place where an individual lives, such as:

a. A private home,

b. A nursing care institution, or

c. An assisted living facility.

71. "Resident" means the same as in:

a. A.A.C. R9-10-701, or

b. A.A.C. R9-10-901.

72. "Revenue code" means a code for a unit of service that a hospital includes on a bill for hospital services.

73. "Secondary diagnosis" means any diagnosis for an individual other than the principal diagnosis.

74. "Self-pay discount" means a reduction in charges billed to an individual.

75. "Service" means an activity performed as part of medical services, hospital services, nursing services, emergency services, health-related services, hospice services, home health services, or supportive services.

76. "Supportive services" means the same as in A.R.S. § 36-151.

77. "Transfer" means discharging an individual from a health care institution so the individual may be admitted to another health care institution.

78. "Trauma center" means the same as in:

    a. A.R.S. § 36-2201, or

    b. A.R.S. § 36-2225.

79. "Treatment" means the same as in R9-10-101.

80. "Type of" means a specific subcategory of the following that is provided, enumerated, or utilized by a health care institution:

    a. An employee or contracted worker;

    b. An accounting concept, such as asset, liability, or revenue;

    c. A non-covered ancillary charge;

    d. A payer source;

    e. A charge source;

    f. A medical condition; or

    g. A service.

81. "Type of bed" means a category of available bed that specifies the services provided to an individual occupying the available bed.

82. "Unit" means an area within a health care institution that is designated by the health care institution to provide a specific type of service.

83. "Unit of service" means a procedure, service, commodity, or other item or group of items provided to a patient or resident for which a health care institution bills a payer source a specific amount.

84. "Written notice" means a document that is provided:

    a. In person,

    b. By delivery service,

    c. By facsimile transmission,

    d. By electronic mail, or

    e. By mail.

ARTICLE 2. ~~UNIFORM ACCOUNTING SYSTEM~~

ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS

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R9-11-201. ~~Annual Filing of Operating Statements and Reports~~ Definitions

~~**A.** Every hospital, nursing care institution and inpatient hospice shall submit to the Director not later than 120 days following the institution's fiscal year end the following statements and reports for the reporting year:~~

~~1. Hospitals shall file:~~

~~a. A report of an audit by an independent certified public accountant conducted in accordance with generally accepted auditing standards in the format defined in A.R.S. § 36-125.04(B).~~

~~b. A copy of the hospital's annual Medicare Cost Report.~~

~~c. A copy of the uniform accounting report pursuant to R9-11-202.~~

~~2. Nursing care institutions (NCI) shall submit a completed Arizona Reporting System for Nursing Institutional Costs (ARSNIC) forms set as their uniform accounting report, and a copy of the annual Medicare Cost Report. The ARSNIC report shall be submitted to the Department in electronic and paper copy format.~~

~~3. Inpatient Hospice: Revenue, patient statistics, and expenses related to operating an inpatient hospice shall be delineated either in the Medicare Cost Report for Hospitals or ARSNIC for Nursing Care Institutions.~~

~~**B.** The Director may grant a 30-day extension in writing in advance of the due date of any required reports. The health care facility shall request such extension in writing at least 30 days prior to the due date pursuant to A.R.S. § 36.125.04. The request for extension of time shall include the following:~~

~~1. Name and address of the facility,~~

~~2. Reason for the request,~~

~~3. Requested due date,~~

~~4. Name(s) of the operating statements or reports for which an extension is being requested.~~

In this Article, unless otherwise specified:

1. "Accredited" means the same as in A.R.S. § 36-422.
2. "ALTCS" means the Arizona Long-term Care System established under A.R.S. § 36-2932.
3. "Asset" means the same as "asset" in generally accepted accounting principles.
4. "Audit" means the same as "audit" in generally accepted accounting principles.
5. "Bereavement services" means activities provided by or on behalf of a hospice to the family or friends of an individual that are intended to comfort the family or friends before and after the individual's death.

6. "Building improvement" means an addition to or reconstruction, removal, or replacement of any portion or component of an existing building that affects licensed capacity, increases the useful life of an available bed, or enhances resident safety.
7. "Caseload" means the number of assigned patients for which an individual working for a hospice is to provide hospice services.
8. "Certified nursing assistant" means the same as "nursing assistant" in A.R.S. § 32-1601.
9. "Chaplain" means an individual trained to offer support, prayer, and spiritual guidance to a patient and the patient's family.
10. "Continuous care" means hospice services provided in a patient's residence to a patient who requires nursing services to be available 24 hours a day.
11. "Contracted worker" means an individual who:
    a. Performs:
        i. Hospital services in a hospital,
        ii. Nursing services or health-related services in a nursing care institution,
        iii. Hospice services for a hospice, or
        iv. Labor as a medical record coder or transcriptionist for a hospital; and
    b. Is paid by a person with whom the hospital, nursing care institution, or hospice has a written agreement to provide hospital services, nursing services, health-related services, hospice services, or medical record coder or transcriptionist labor.
12. "Covered services" means hospice services that are provided to an individual by a hospice and are paid for by a payer source.
13. "Daily census" means a count of the number of patients to whom hospice services were provided during a 24-hour period.
14. "Direct care" means services provided to a resident that require hands-on contact with the resident.
15. "Direction" means the same as in A.R.S. § 36-401.
16. "Employee" means an individual other than a contracted worker who works for a health care institution for compensation and provides or assists in the provision of a service to patients or residents.
17. "Employee-related expenses" means costs incurred by an employer to pay for the employer's portion of Social Security taxes, Medicare taxes, and other costs such as health insurance.
18. "Equity" means the same as "equity" in generally accepted accounting principles.

19. "Expense" means the same as "expense" in generally accepted accounting principles.
20. "Free-standing" means that a health care institution is not located within another health care institution.
21. "FTE" means full-time equivalent position, which is a job for which a health care institution expects to pay an individual for 2,080 hours per year.
22. "Generally accepted accounting principles" means the set of financial reporting standards administered by the Financial Accounting Standards Board or the Governmental Accounting Standards Board.
23. "Health professional" means the same as in A.R.S. § 32-3201.
24. "Home health agency-based hospice" means a hospice that operates as part of a home health agency.
25. "Hospice administrator" means the chief administrative officer for a hospice.
26. "Hospice chief financial officer" means an individual who is responsible for the financial records of a hospice.
27. "Hospice inpatient facility" means the same as in A.A.C. R9-10-801.
28. "Hospice service" means the same as in A.A.C. R9-10-801.
29. "Hospice service agency" means the same as in A.R.S. § 36-401.
30. "Hospital-based hospice" means a hospice that is located within a hospital.
31. "Inpatient services" means the same as in A.A.C. R9-10-801.
32. "Inpatient surgery" means surgery that requires a patient to receive inpatient services in a hospital.
33. "Level of care" means a designation that indicates the scope of medical services, nursing services, and health-related services that are provided to a patient or resident.
34. "Liability" means the same as "liability" in generally accepted accounting principles.
35. "Licensed nurse" means a registered nurse practitioner, registered nurse, or practical nurse.
36. "Licensee" means the same as in R9-10-101.
37. "Median length of stay" means the midpoint in the number of patient care days for all patients who were discharged from a hospice during a specific period of time.
38. "Medicaid" means a federal health insurance program, administered by states, for individuals who meet specific income criteria established, in Arizona, by AHCCCS.
39. "Medical record coder" means an individual who assigns codes to a patient's diagnoses and procedures for billing purposes.

40. "Medical record transcriptionist" means an individual who copies and edits dictation from medical practitioners into medical records.
41. "Medical records" mean the same as in A.R.S. § 12-2291.
42. "Medicare cost report" means the annual financial and statistical documents submitted to the United States Department of Health and Human Services as required by Title XVIII of the Social Security Act.
43. "Medicare-certified" means that a health care institution is authorized by the United States Department of Health and Human Services to bill Medicare for services provided to patients or residents who are eligible to receive Medicare.
44. "Midnight census" means a count of the number of patients or residents in a health care institution at 12:00 a.m.
45. "Net assets" means the same as "net assets" in generally accepted accounting principles.
46. "Non-covered ancillary services" means activities, such as rehabilitation services, laboratory tests, or x-rays, provided to an individual in a health care institution that are paid for by:
    a. A payer source other than ALTCS, or
    b. ALTCS to an entity that is not a health care institution.
47. "Nursery patient" means a newborn who was born in a hospital and not admitted to a type of bed that is counted toward the hospital's licensed capacity.
48. "Nursing care institution-based hospice" means a hospice that is located within a nursing care institution.
49. "Nursing personnel" means the individuals authorized by a health care institution to provide nursing services to a patient or resident.
50. "Occupancy rate" means the midnight census divided by the number of available beds, expressed as a percent.
51. "Operating expense" means the same as "operating expense" in generally accepted accounting principles.
52. "Outpatient hospice services" means hospice services provided at a location outside a hospice inpatient facility.
53. "Outpatient surgery" means surgery that does not require a patient to receive inpatient services in a hospital.
54. "Owner" means the same as in A.A.C. R9-10-101.
55. "Patient care day" means a calendar day during which a hospice provides hospice services to a patient.

56. "Patient day" means a period during which a patient received inpatient services with:
    a. The time between the midnight census on two successive calendar days counting as one period, and
    b. The day of discharge being counted only when the patient is admitted and discharged on the same day.
57. "Person" means the same as in A.R.S. § 41-1001.
58. "Practical nurse" means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice practical nursing, as defined in A.R.S. § 32-1601.
59. "Registered nurse" means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice professional nursing, as defined in A.R.S. § 32-1601.
60. "Rehabilitation services" means the same as in A.A.C. R9-10-201.
61. "Resident day" means a period during which a resident received nursing services or health-related services provided by a nursing care institution with:
    a. The time between the midnight census on two successive calendar days counting as one period, and
    b. The day of discharge being counted only when the resident is admitted and discharged on the same day.
62. "Respite care services" means the same as in A.R.S. § 36-401.
63. "Revenue" means the same as "revenue" in generally accepted accounting principles.
64. "Routine home care" means hospice services provided in a patient's residence to a patient who does not require nursing services to be available 24 hours a day.
65. "Rural" means the same as in A.R.S. § 36-2171.
66. "Self-pay" means that charges for hospice services are billed to an individual.
67. "Social worker" means an individual licensed according to A.R.S. §§ 32-3291, 32-3292, or 32-3293.
68. "Statement of cash flows" means the same as "statement of cash flows" in generally accepted accounting principles.
69. "Surgery" means the excision of a part of a patient's body or the incision into a patient's body for the correction of a deformity or defect; repair of an injury; or diagnosis, amelioration, or cure of disease.
70. "Turnover rate" means:
    a. For a hospital, a percent calculated by dividing the number of individuals employed by the hospital who resign or retire from or are dismissed by the

hospital during a reporting period by the average number of individuals employed during the reporting period; or

b. For a nursing care institution, a percent calculated by dividing the number of employees who resign or retire from or are dismissed by a nursing care institution during a reporting period by the average number of employees during the reporting period.

71. "Uniform accounting report" means a document that meets the requirements of A.R.S. § 36-125.04 and contains the information required in R9-11-203 for hospitals, R9-11-204 for nursing care institutions, and R9-11-205 for hospices.

72. "Unscheduled medical services" means the same as in A.R.S. § 36-401.

73. "Urban" means an area not defined as "rural."

74. "Urgent care unit" means a facility under a hospital's license that is:

a. Located within one-half mile of the hospital, and

b. Designated by the hospital for the provision of unscheduled medical services for medical conditions that are of a less critical nature than emergency medical conditions.

75. "Vacancy rate" means a percent calculated by dividing the number of unfilled FTEs at the end of a hospital's reporting period by the sum of the unfilled FTEs and filled FTEs at the end of the hospital's reporting period.

76. "Volunteer" means the same as in A.A.C. R9-10-801.

R9-11-202. ~~Expired~~ Hospital Annual Financial Statement

A. A hospital administrator or designee shall submit to the Department, no later than 120 calendar days after the ending date of the hospital's fiscal year:

1. An annual financial statement prepared according to generally accepted accounting principles, and

2. A report of an audit by an independent certified public accountant of the annual financial statement required in subsection (A)(1).

B. If a hospital is part of a group of health care institutions that prepares a combined annual financial statement and is included in the combined annual financial statement, the hospital administrator or designee may submit the combined annual financial statement if the combined annual financial statement:

1. Is prepared according to generally accepted accounting principals,

2. Identifies the hospital, and

3. Contains a financial statement specific to the hospital.

C. The Department shall grant a hospital a 30-day extension for submitting an annual financial statement and audit of the annual financial statement required in subsection (A) if the hospital administrator or designee submits a written request for an extension that:

1. Includes the name, physical address, mailing address, and telephone number of the hospital;
2. Includes the name, telephone number, mailing address, and e-mail address of:
   a. The hospital administrator; and
   b. An individual, in addition to the hospital administrator, who may be contacted about the extension request;
3. Includes the date the hospital's annual financial statement and audit of the annual financial statement is due to the Department;
4. Specifies that the hospital is requesting a 30-day extension from submitting the annual financial statement and audit of the annual financial statement required in subsection (A); and
5. Is submitted to the Department at least 30 calendar days before the annual financial statement and audit of the annual financial statement is due to the Department.

D. The Department shall send a written notice of approval of a 30-day extension to a hospital that submits a request for an extension that meets the requirements specified in subsection (C) within seven business days after receiving the request.

E. If a request by a hospital administrator or designee for a 30-day extension does not meet the requirements specified in subsection (C), the Department shall provide to the hospital a written notice that specifies the missing or incomplete information. If the Department does not receive the missing or incomplete information within 10 calendar days after the date on the written notice, the Department shall consider the hospital's request withdrawn.

F. Before the end of the 30-day extension specified in subsection (C), a hospital administrator or designee may request an additional extension for submitting an annual financial statement and audit of the annual financial statement by submitting a written request that:

1. Includes the information specified in subsections (C)(1) through (C)(3),
2. Specifies for how many calendar days the hospital is requesting an extension from submitting the annual financial statement and audit of the annual financial statement,
3. Is submitted to the Department at least 14 calendar days before the annual financial statement and audit of the annual financial statement is due to the Department, and
4. Includes the reasons for the additional extension request.

G. In determining whether to approve or deny a request for a hospital to receive an additional extension as specified in subsection (F) for submitting an annual financial statement and audit of the annual financial statement, the Department shall consider the following:

1. The reasons for the additional extension request provided according to subsection (F)(4);
2. The length of time for which the additional extension is being requested provided according to subsection (F)(2); and
3. If the hospital has a history of the following items:
   a. Repeated violations of the same statutes or rules,
   b. Patterns of noncompliance with statutes or rules,
   c. Types of violations of statutes or rules,
   d. Total number of violations of statutes or rules,
   e. Length of time during which violations of statutes or rules have been occurring, and
   f. Noncompliance with an agreement between the Department and the hospital.

H. The Department shall send written notice of approval or denial to a hospital that requests an additional extension specified in subsection (F) for submitting an annual financial statement and audit of the annual financial statement within seven business days after receiving the request.

I. If the Department denies a request for an additional extension specified in subsection (F), a hospital may appeal the denial according to A.R.S. Title 41, Chapter 6, Article 10.

J. If a hospital administrator or designee does not submit an annual financial statement and a report of an audit of the annual financial statement according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

R9-11-203. ~~**Expired**~~ **Hospital Uniform Accounting Report**

A. A hospital administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, no later than 150 calendar days after the ending date of the hospital's fiscal year.

B. A hospital administrator or designee shall submit a copy of the hospital's Medicare cost report, if applicable, as part of the uniform accounting report required in subsection (A).

C. The uniform accounting report required in subsection (A) shall include the following information:

1. The name, physical address, mailing address, county, and telephone number of the hospital;
2. The name, telephone number, and e-mail address of the:
   a. Hospital administrator,
   b. Hospital chief financial officer, and

c. Individual who prepared the uniform accounting report;

3. The identification number assigned to the hospital:

a. By the Department;

b. By AHCCCS;

c. By Medicare, if applicable; and

d. As the hospital's national provider identifier;

4. The hospital's classification;

5. Whether the entity that is the owner of the hospital is:

a. Not for profit;

b. For profit; or

c. A federal, state, or local government agency;

6. Whether or not the hospital is Medicare-certified;

7. The ending date of the hospital's reporting period;

8. If the hospital began operations during the hospital's reporting period, the date on which the hospital began operations;

9. The date the uniform accounting report was submitted to the Department;

10. The licensed capacity, for each type of bed, at the end of the reporting period;

11. The licensed capacity at the end of the reporting period;

12. The number of available beds, for each type of bed, at the end of the reporting period;

13. The number of available beds at the end of the reporting period;

14. The number of admissions, for each type of bed, during the reporting period;

15. The total number of admissions during the reporting period;

16. The total number of patient days:

a. During the reporting period, and

b. For each type of bed during the reporting period;

17. The average occupancy rate for the reporting period;

18. The number of inpatient surgeries during the reporting period;

19. The number of outpatient surgeries during the reporting period;

20. The number of births during the reporting period;

21. The number of nursery patient admissions during the reporting period;

22. The number of patient days for nursery patients during the reporting period;

23. The number of episodes of care during the reporting period provided by the:

a. Emergency department,

b. Urgent care unit, and

c. Trauma center;

24. The total number of episodes of care during the reporting period provided by the emergency department, urgent care unit, or trauma center;

25. The number of episodes of care in the emergency department, urgent care unit, or trauma center during the reporting period for which the patient was subsequently admitted to the hospital;

26. The total number of FTEs at the end of the reporting period;

27. The vacancy rate for the reporting period;

28. The turnover rate for the reporting period;

29. The number of FTEs, for each type of employee, during the reporting period;

30. The vacancy rate, for each type of employee, for the reporting period;

31. The number of medical record coder FTEs during the reporting period;

32. The vacancy rate for medical record coders for the reporting period;

33. The number of medical record transcriptionist FTEs during the reporting period;

34. The vacancy rate for medical record transcriptionists for the reporting period;

35. For individuals who worked for the hospital as contracted workers during the reporting period, the number of hours worked by registered nurses;

36. The amount of revenue generated, for each type of revenue, by the hospital during the reporting period;

37. The amount of allowances given, for each type of allowance, by the hospital during the reporting period;

38. The total amount of revenue generated and allowances given by the hospital during the reporting period;

39. The operating expenses incurred, for each type of operating expense, by the hospital during the reporting period;

40. The total operating expenses incurred by the hospital during the reporting period;

41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);

42. The expenses, other than operating expenses, for each type of expense, incurred by the hospital during the reporting period;

43. The amount of assets, for each type of asset, of the hospital at the end of the reporting period;

44. The total amount of assets of the hospital at the end of the reporting period;

45. The amount of liabilities, for each type of liability, of the hospital at the end of the reporting period;

46. The total amount of liabilities of the hospital at the end of the reporting period;

47. The amount of net assets, for each type of net asset, of the hospital at the end of the reporting period;

48. The total amount of net assets of the hospital at the end of the reporting period;

49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46); and

50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3), unless the statement of cash flows has been submitted as part of the annual financial statement required in R9-11-202.

D. A hospital administrator or designee shall:

1. Attest, on a form provided by the Department, that, to the best of the knowledge and belief of the hospital administrator or designee**,** the information submitted according to subsections (B) and (C) is accurate and complete; and

2. Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

E. A hospital administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospital administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

ARTICLE 3. RATES AND CHARGES SCHEDULES

R9-11-301. ~~Filing of Rates and Charges~~ Definitions

~~**A.** Each hospital, nursing care institution, supervisory care facility, and home health agency shall file with the Department all schedules of rates or charges, and other information specified in subsection (F) of this rule. This information shall be regarded as the existing schedule of rates or charges for such institutions.~~

~~**B.** A new hospital, nursing care institution, supervisory care facility or home health agency shall not engage in business within this state until its schedule of rates or charges has been filed with the Department and reviewed as provided in A.R.S. § 36-436 et seq.~~

~~**C.** No rate or charge for a new service or procedure shall be implemented by a hospital or nursing care institution until the requirements of A.R.S. § 36-421 and § 36-436 have been completed in accordance with the following:~~

~~1. Rates or charges for a new service or procedure not requiring a permit pursuant to A.R.S. § 36-421 shall be filed with the Director and accompanied by a per-unit cost analysis using direct expense by natural classification, and number of units anticipated over a 12-month period. The Director may issue written findings. Upon submission of all required information, rates will be effective no later than 60 days subsequent to the filing. A schedule of rates and charges for a new service not requiring a permit shall be submitted no more than once quarterly.~~

~~2. Rates or charges for a new service or procedure requiring a permit pursuant to A.R.S. § 36-421 shall be accompanied by an analysis consisting of two consecutive 12-month periods projecting each of the following elements:~~

~~a. Volume in units,~~

~~b. Gross Revenue,~~

~~c. Deductions from Revenue,~~

~~d. Direct expenses by natural classification, and~~

~~e. Indirect expenses.~~

~~**D.** No decrease or deletion shall be made by any hospital or nursing care institution in any rate or charge until the proposed decrease or deletion has been filed for informational purposes with the Director.~~

~~**E.** Supervisory care and home health agencies shall submit to the Department increases in rates or charges 30 days prior to implementation.~~

~~**F.** All schedules of rates or charges required to be filed shall include each service and item for which a separate charge is made. The schedule of rates or charges must contain the following information:~~

~~1. Facility License Number;~~

~~2. Facility Name;~~

~~3. Table of contents or record layout that defines the order or sort of the information that would enable the Department to easily locate items by charge code within each department;~~

4. Department Name and Number;
5. Charge Code;
6. Service description;
7. Existing Charge;
8. Proposed Charge;
9. A copy of all rules, criteria and discounts, such as acuity methodology, pricing rationale, and formulae which may in any way change, affect or determine any part of the aggregate of the rates or charges therein or the value of the services or commodities covered by the schedule.

G. The schedule of rates or charges may be submitted in an electronic format if written approval has been granted by the Department prior to submission.

H. Charges for expendable items received from an outside supplier (excluding capital items for which the patient does not acquire ownership), which are generally numerous in quantity and subject to frequent cost changes, such as pharmacy or central supply items, may be listed on the schedule of rates and charges in the form of a formula, provided that the formula is adopted as a rule or regulation of the institution. The formula shall include, but is not limited to, the following elements:

1. The net purchase cost of the item, which shall reflect all invoiced discounts, allowances or rebates.
2. The percent of cost or dollar markup.

I. If the formula method of listing rates and charges is used, the institution is not required to report or file those rate changes resulting exclusively from a change in the net purchase cost of the item to the institution. Any change in other elements of the formula shall constitute a change in the rate schedule and will require filing of the proposed new rate as provided in A.R.S. §§ 36-436.02 and 36-436.03.

J. If a charge is priced for outside services rendered by those individuals licensed pursuant to A.R.S. Title 32 or facilities licensed pursuant to A.R.S. Title 36, Article 4, the schedule of rates and charges shall include the pricing policy or formula.

K. The effective date of a proposed schedule of rates or charges of a new institution or of a change in the schedule of rates or charges of an existing institution shall be as determined by the institution but not earlier than:

1. The date of the findings of the Director, or

~~2. Sixty days after the date of filing the proposed schedule together with all supporting data required by A.R.S. § 36-436 and subsections (F) through (J) of this Section, whichever occurs first.~~

~~**L.** The filing date shall be determined by the Department as defined in R9-11-303 and R9-11-305.~~

~~**M.** If increased rates or charges are not reflected on the patient bills along with discounts, if any, within 30 days after the review period has expired, the institution abandons its right to implement the increased schedule of rates or charges unless written consent is granted by the Director prior to the expiration of the 30-day period.~~

In this Article, unless otherwise specified:

1. "Adolescent" means an individual the hospital designates as an adolescent based on the hospital's criteria.
2. "Adult" means the same as in A.A.C. R9-10-201.
3. "Behavioral health service" means the same as in A.A.C. R9-20-101.
4. "Blood bank cross match" means a laboratory analysis, performed by a facility that stores and preserves donated blood, to test the compatibility of a quantity of blood donated by one individual with another individual who is the intended recipient of the blood.
5. "Complete blood count with differential" means enumerating the number of red blood cells, platelets, and white blood cells in a sample of an individual's blood, and including in the enumeration of white blood cells the number of each type of white blood cell.
6. "Contrast medium" means a substance opaque to x-rays, radio waves, or electromagnetic radiation that enhances an image of internal body structures.
7. "CT" means Computed Tomography, a diagnostic procedure in which x-ray measurements from many angles are used to provide images of internal body structures.
8. "Current rates and charges information" means the most recent rates and charges schedule for a health care institution on file with the Department, plus all documents changing the most recent rates and charges schedule.
9. "Drug" means the same as in A.R.S. § 32-1901.
10. "EEG" means electroencephalogram, a diagnostic procedure used to measure the electrical activity of the brain.
11. "EKG" means electrocardiogram, a diagnostic procedure used to measure the electrical activity of the heart.
12. "Facility" means a building and associated personnel and equipment that perform a particular service or activity.
13. "Formulary" means a list of drugs that are available to a patient through a hospital.

14. "Home health agency" means the same as in A.R.S. § 36-151.
15. "Home health agency administrator" means the chief administrative officer for a home health agency.
16. "Hospital department" means a subdivision of a hospital providing administrative oversight for one or more charge sources.
17. "Implementation date" means the month, day, and year a health care institution intends to begin using specific rates and charges when billing a patient or resident.
18. "Intensive care bed" means an available bed used to provide intensive care services, as defined in A.A.C. R9-10-201, to a patient.
19. "IVP" means intravenous pyelography, a diagnostic procedure that uses an injection of a contrast medium into a vein and x-rays to provide images of the kidneys, ureters, bladder, and urethra.
20. "Labor and delivery" means services provided to a woman related to childbirth.
21. "Lithotripsy" means a procedure that uses sound waves to break up hardened deposits of mineral salts inside the human body.
22. "Mark-up" means the difference between the dollar amount a hospital pays for a drug, commodity, or service and the charge billed to a patient.
23. "MRI" means Magnetic Resonance Imaging, a diagnostic procedure that uses a magnetic field and radio waves to provide images of internal body structures.
24. "Neonate" means the same as in A.A.C. R9-10-201.
25. "Nursery bed" means an available bed used to provide hospital services to a neonate.
26. "Outpatient treatment center" means the same as in A.A.C. R9-10-101.
27. "Outpatient treatment center administrator" means the chief administrative officer for an outpatient treatment center.
28. "Overview form" means a document:
    a. Submitted by a hospital to the Department as part of a rates and charges schedule or a change to the hospital's current rates and charges information, and
    b. That contains the information required in R9-11-302(B)(2) for the hospital.
29. "Pediatric" means the same as in A.A.C. R9-10-201.
30. "Pediatric bed" means an available bed used to provide hospital services to a pediatric patient.
31. "Physical therapy" means the same as in A.R.S. § 32-2001.
32. "Post-hospital extended care services" means the services that are described in and meet the requirements of 42 CFR 409.31.

33. "Private room" means a room that contains one available bed.

34. "Rate" means a specific dollar amount per unit of service set by a health care institution.

35. "Rates and charges schedule" means a document that meets the requirements of A.R.S. Title 36, Chapter 4, Article 3 and contains the information required in R9-11-302(B) for hospitals, R9-11-303(A)(2) for nursing care institutions, R9-11-304(A)(2) for home health agencies, or R9-11-305(A)(2) for outpatient treatment centers.

36. "Review" means an analysis of a document to ensure that the document is in compliance with the requirements of this Article.

37. "Semi-private room" means a room that contains two available beds.

38. "Skilled nursing bed" means an available bed used for a patient requiring skilled nursing services.

39. "Skilled nursing services" means nursing services provided by an individual licensed under A.R.S. Title 32, Chapter 15.

40. "Small volume nebulizer" means a device that:

    a. Holds liquid medicine that is turned into a mist by an air compressor, and

    b. Is used for treatments lasting less than 20 minutes.

41. "Swing bed" means an available bed for which a hospital has been granted an approval from the Centers for Medicare and Medicaid Services to provide post-hospital extended care services and be reimbursed as a swing-bed hospital.

42. "Swing-bed hospital" means the same as in 42 CFR 413.114.

43. "Trauma team activation" means a notification by a health care institution:

    a. That alerts individuals designated by the health care institution to respond to a particular type of emergency;

    b. That is based on a patient's triage information; and

    c. For which the health care institution uses Revenue Category 068X of the National Uniform Billing Committee, UB-04 Data Specifications Manual to bill charges.

44. "Ultrasound" means a diagnostic procedure that uses high-frequency sound waves to provide images of internal body structures.

R9-11-302. ~~Expired~~ Hospital Rates and Charges Schedule

A. Before a hospital provides services to patients, a hospital administrator or designee shall submit to the Department a rates and charges package that contains:

1. A cover letter that includes:

a. The name, physical address, mailing address, county, and telephone number of the hospital;

b. The identification number assigned to the hospital:

i. By the Department;

ii. By AHCCCS;

iii. By Medicare, if applicable; and

iv. As the hospital's national provider identifier;

c. The name, telephone number, and e-mail address of:

i. The hospital administrator,

ii. The hospital chief financial officer, and

iii. Another individual involved in the preparation of the rates and charges package whom the Department may contact regarding the rates and charges package; and

d. The planned implementation date for the rates and charges;

2. A rates and charges schedule prepared as specified in subsection (B); and

3. A statement signed by the hospital administrator or designee, on a form provided by the Department, attesting that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsections (A)(1) and (B) is accurate and complete.

B. A hospital administrator shall ensure that a rates and charges schedule:

1. Contains a table of contents for the rates and charges schedule that lists:

a. The beginning line number or page number for the hospital rates and charges overview form required in subsection (B)(2);

b. For each hospital department:

i. The hospital department's name and identification number,

ii. The beginning line number or page number of the rates and charges schedule for the hospital department, and

iii. The charge source's name and identification number for each charge source within the hospital department;

c. The beginning line number or page number for the list required in subsection (B)(4) that matches the name of each charge source with its charge source identification number;

d. The beginning line number or page number for the formula section for formulary, commodity, and contracted services mark-ups required in subsection (B)(5); and

e. The beginning line number or page number for the copy of the hospital's allowance rules and formulae required in subsection (B)(6);

2. Contains an overview form, in a format specified by the Department, that includes:

a. The hospital's name, city, and county;

b. The identification number assigned to the hospital by the Department;

c. The name, telephone number, and e-mail of the individual who prepared the overview form;

d. The date the overview form was submitted to the Department;

e. The hospital's licensed capacity;

f. Whether the entity that is the owner of the hospital is:

i. Not for profit;

ii. For profit; or

iii. A federal, state, or local government agency;

g. The hospital's classification;

h. The planned implementation date for the rates and charges in the overview form;

i. The total percent increase of the rates and charges listed in the overview form compared with the rates and charges from the last overview form;

j. The date the overview form was last changed;

k. The daily charge for a private room;

l. The daily charge for a semi-private room;

m. The daily charge for a pediatric bed;

n. The daily charge for a nursery bed;

o. The daily charge for a pediatric intensive care bed;

p. The daily charge for a neonatal intensive care bed;

q. The daily charge for a cardiovascular intensive care bed;

r. The daily charge for a swing bed;

s. The daily charge for a rehabilitation bed;

t. The daily charge for a skilled nursing bed;

u. The minimum charges for labor and delivery;

v. The minimum charge for trauma team activation;

w. The minimum charge for an EEG;

x. The minimum charge for an EKG;

y. The minimum charge for a complete blood count with differential;

z. The minimum charge for a blood bank crossmatch;

aa. The minimum charge for a lithotripsy;

bb. The minimum charge for an x-ray;

cc. The minimum charge for an IVP;

dd. The minimum charge for a respiratory therapy session with a small volume nebulizer;

ee. The minimum charge for a CT scan of a head without contrast medium;

ff. The minimum charge for a CT scan of an abdomen with contrast medium;

gg. The minimum charge for an abdomen ultrasound;

hh. The minimum charge for a brain MRI without contrast medium;

ii. The minimum charge for 15 minutes of physical therapy; and

jj. The daily rate for behavioral health services for:

i. An adult patient,

ii. An adolescent patient, and

iii. A pediatric patient;

3. Lists for each hospital department, in a format specified by the Department:

a. The hospital department name and identification number;

b. The charge source name and identification number for each charge source within the hospital department; and

c. For each unit of service offered by the hospital for which a separate rate or charge is billed from the charge source:

i. The unit of service code,

ii. A description of the unit of service,

iii. The rate or charge for the unit of service, and

iv. The number of times a separate charge was billed for the unit of service during the previous 12 months;

4. Contains a list that matches the name of each charge source with its charge source identification number;

5. Contains a formula section for formulary, commodity, and contracted services mark-ups; and

6. Contains a copy of the hospital's allowance rules and formulae, if applicable.

C. To change a hospital's current rates and charges information, a hospital administrator or designee shall submit to the Department:

1. A cover letter:

a. Containing the information specified in subsection (A)(1), and

b. Stating that the accompanying information is changing the hospital's current rates and charges information;

2. Either:

a. The rates and charges schedule specified in subsection (A)(2); or

b. The following information:

i. A description of:

(1) The current and new rate or charge for each unit of service undergoing a change;

(2) The name of each charge source undergoing a change and its charge source identification number;

(3) The current and new formulary, commodity, and contracted services formulae for each change in the hospital's mark-up;

(4) The current and new allowance rules and formulae for each change in the hospital's allowance rules and formulae; and

(5) How the hospital rates and charges overview form required in subsection (B)(2) is affected by the changes specified in subsections (C)(2)(b)(i)(1) through (C)(2)(b)(i)(4);

ii. The line number or page number in the hospital's current rates and charges information for each change listed in subsection (C)(2)(b)(i); and

iii. A list of each previous change:

(1) To a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula being changed;

(2) That was submitted since the last rates and charges schedule submitted according to subsection (A)(2) or (C)(2)(a); and

(3) Including:

(a) The date the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and

(b) A description of how the rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula was previously changed; and

3. A statement signed by the hospital administrator or designee, on a form provided by the Department, attesting that, to the best of the knowledge and belief of the hospital

administrator or designee, the information submitted according to subsections (C)(1) and (C)(2) is accurate and complete.

D. A hospital administrator shall implement rates and charges for a rates and charges schedule, submitted as specified in subsection (A), on a date determined by the hospital but not earlier than:

1. The date the Department notifies the hospital that the Department has completed a review of the rates and charges schedule, or
2. Sixty calendar days after the Department notifies the hospital that the Department received the rates and charges schedule.

E. A hospital administrator shall implement a change in the hospital's current rates and charges information submitted as specified in subsection (C):

1. That is:
   a. A new rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;
   b. An increase in a rate or charge;
   c. A change to a formulary, commodity, or contracted services formula, which results in an increase in a rate or charge; or
   d. A change to an allowance rule or formula, which results in an increase in a rate or charge; and
2. On a date determined by the hospital, but not earlier than:
   a. The date the Department notifies the hospital that the Department has completed a review of the information submitted as specified in subsection (C), or
   b. Sixty calendar days after the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).

F. A hospital administrator shall implement a change in the hospital's current rates and charges information submitted as specified in subsection (C):

1. That is:
   a. A deletion of a rate; charge; charge source; formulary, commodity, or contracted services formula; or allowance rule or formula;
   b. A reduction in a rate or charge;
   c. A change to a formulary, commodity, or contracted services formula, which results in a reduction in a rate or charge; or
   d. A change to an allowance rule or formula, which results in a reduction in a rate or charge; and
2. On a date:

a. Determined by the hospital, and

b. Not earlier than the date the Department notifies the hospital that the Department received the information submitted as specified in subsection (C).

G. When the Department receives from a hospital a rates and charges schedule submitted as specified in subsection (A), or a change in the hospital's current rates and charges information submitted as specified in subsection (C), the Department shall:

1. Provide written notice to the hospital within five business days of receipt of the rates and charges information, and
2. Provide written notice to the hospital within 60 calendar days that the Department has reviewed the rates and charges information.

H. A hospital administrator, who receives a request from the Department for a revision of a rates and charges schedule not prepared as specified in subsection (A) or for a revision of a change in the hospital's current rates and charges information not prepared as specified in subsection (C), shall ensure that the revised rates and charges schedule or the revised information changing the current rates and charges information is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
2. Within seven calendar days after the date on the Department's letter requesting a second revision.

I. If a hospital administrator or designee does not submit a rates and charges schedule or information about changes to the hospital's rates or charges according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-431.01.

ARTICLE 4. HOSPITAL INPATIENT DISCHARGE REPORTING ~~FOR INPATIENTS~~

R9-11-401. Definitions

~~In this Article, unless the context otherwise requires:~~

~~1. "AHCCCS" means the Arizona Health Care Cost Containment System.~~

~~2. "AHCCCS/Medicaid" means care provided pursuant to A.R.S. § 36-2905.~~

~~3. "AHCCCS Health Group" means reimbursement for care provided to non-AHCCCS eligible clients but who are enrolled with the AHCCCS through their employer health group plan.~~

~~4. "BPI" means bits per inch.~~

~~5. "Charity" means reduction in charges for services made by the health care institution because of the indigence of the patient but does not include Title XIX, AHCCCS, contractual obligations of the facility, or other third-party payor settlements.~~

~~6. "EBCDIC" means extended binary coded decimal interchange code.~~

~~7. "E code" means the environmental events, circumstances, and conditions that caused the injury, poisoning, and other adverse effects.~~

~~8. "Foreign national" means reimbursement of a hospital for care provided to another country's national health care system client.~~

~~9. "HMO" means a health maintenance organization.~~

~~10. "Home IV provider" means individuals or organizations who assist in the delivery of drugs and devices to patients pursuant to A.R.S. Title 32, Chapter 18.~~

~~11. "Hospital identification number" means the federal tax identification number.~~

~~12. "ICD" means international classification of diseases.~~

~~13. "Medicare risk" means contracted services provided by a HMO that represent an alternate method to the federal system of delivering services to individuals 65 and over.~~

~~14. "Patient" means a person who is admitted to the hospital as an inpatient only.~~

~~15. "Patient certificate/social security number" means an insured's unique identification number utilized by the payer organization.~~

~~16. "Patient control number" means the medical record number or other hospital-assigned number for patient identification purposes.~~

~~17. "Payer code" means the expected primary source of payment for the majority of the charges associated with treatment.~~

~~18. "Physician number" means the state license number of an individual licensed pursuant to A.R.S. Title 32.~~

~~19. "PPO" means a preferred provider organization.~~

~~20. "Self pay" means payment made directly by the patient, guarantor, relatives, or friends for a patient who does not have medical insurance.~~

~~21. "SNF" means a skilled nursing facility pursuant to A.R.S. Title 36, Article 7.~~

~~22. "Total patient charges" means the gross charges incurred by a patient that are billed by the hospital.~~

In this Article, unless otherwise specified:

1. "Admitting diagnosis" means the reason an individual is admitted to a hospital.
2. "DRG" means Diagnosis Related Group, a type of prospective payment system used in billing for inpatient episodes of care.
3. "HIPPS" means the Health Insurance Prospective Payment System, a type of prospective payment system used by specific health care institutions, such as rehabilitation hospitals, for billing for services provided by the health care institutions.

4. "Inpatient discharge report" means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-402.

5. "Length of stay" means the total number of calendar days for a specific episode of care, from the date of admission to the date of discharge.

R9-11-402. Reporting Requirements

~~**A.** Each hospital shall report statistical and demographic information, as specified in subsections (B) through (E), to the Department for each patient discharged by the hospital, in accordance with the following schedule:~~

~~1. For each patient discharged between January 1 and June 30, the information shall be submitted by August 15; and~~

~~2. For each patient discharged between July 1 and December 31, the information shall be submitted by February 15.~~

~~**B.** Hospitals shall report to the Department the diagnosis, procedures, and revenue codes pertaining to each discharged patient in a uniform format as specified by the UB-92, National Uniform Billing Data Element Specifications, October 8, 1993, Arizona Hospital Association, 1501 West Fountainhead Parkway, Suite 650, Tempe, Arizona 85282, incorporated herein by reference and on file with the Office of the Secretary of State.~~

~~**C.** Hospitals shall submit the following data elements for each discharged patient in accordance with the physical layout in the Table included in this Article:~~

~~1. Hospital identification number,~~

~~2. Patient control number,~~

~~3. Patient certificate/social security number,~~

~~4. Patient race,~~

~~5. Patient street address,~~

~~6. Patient city,~~

~~7. Patient state,~~

~~8. Patient zip code,~~

~~9. Patient date of birth,~~

~~10. Patient sex,~~

~~11. Patient date of admission,~~

~~12. Patient date of discharge,~~

~~13. Patient discharge status,~~

~~14. Diagnostic related group code,~~

~~15. Total patient charges,~~

~~16. Payer code,~~

~~17. Revenue codes:~~

~~a. All inclusive rate,~~

~~b. Room and board - private,~~

~~c. Room and board - two bed,~~

~~d. Room and board - 3 or 4 bed,~~

~~e. Private (deluxe),~~

~~f. Room and board - ward,~~

~~g. Other room and board,~~

~~h. Nursery,~~

~~i. Intensive Care,~~

~~j. Coronary Care,~~

~~k. Special charges,~~

~~l. Incremental charges,~~

~~m. All inclusive ancillary,~~

~~n. Pharmacy,~~

~~o. IV therapy,~~

~~p. Medical/Surgical supplies,~~

~~q. Oncology,~~

~~r. Durable medical equipment (other than renal),~~

~~s. Laboratory,~~

~~t. Laboratory pathology,~~

~~u. Radiology - diagnostic,~~

~~v. Radiology - therapeutic,~~

~~w. Nuclear Medicine,~~

~~x. CT scan,~~

~~y. Operating room,~~

~~z. Anesthesia,~~

~~aa. Blood,~~

~~bb. Blood storage and processing,~~

~~cc. Other imaging,~~

~~dd. Respiratory services,~~

~~ee. Physical therapy,~~

~~ff. Occupational therapy,~~

gg. Speech therapy,

hh. Emergency room,

ii. Pulmonary function,

jj. Audiology,

kk. Cardiology,

ll. Osteopathic services,

mm. Ambulance,

nn. Medical social services,

oo. MRI,

pp. Medical/Surgical supplies (Extension of 27X),

qq. Drugs requiring specific identification,

rr. Cast room,

ss. Recovery room,

tt. Labor/Delivery,

uu. EKG/ECG,

vv. EEG,

ww. Gastrointestinal services,

xx. Treatment/observation room,

yy. Lithotripsy,

zz. Inpatient renal dialysis,

aaa. Organ acquisition,

bbb. Miscellaneous dialysis,

ccc. Psychiatric treatment,

ddd. Psychiatric services,

eee. Other diagnostic services,

fff. Other therapeutic services,

ggg. Professional fees (96X),

hhh. Professional fees (97X),

iii. Professional fees (98X),

jjj. Patient convenience items,

kkk. All other not covered in (a) through (jjj),

18. Physician name,

19. Physician number,

20. Physician licensing board,

~~21. Other physician name,~~

~~22. Other physician number,~~

~~23. Other physician licensing board,~~

~~24. Type of admission,~~

~~25. Source of admission,~~

~~26. Principal diagnosis,~~

~~27. Second diagnosis,~~

~~28. Third diagnosis,~~

~~29. Fourth diagnosis,~~

~~30. Fifth diagnosis,~~

~~31. Sixth diagnosis,~~

~~32. Seventh diagnosis,~~

~~33. Eighth diagnosis,~~

~~34. Ninth diagnosis,~~

~~35. External causes of injury (E code),~~

~~36. Second external cause of injury (E code),~~

~~37. Principal procedure date,~~

~~38. Principal procedure,~~

~~39. Second procedure,~~

~~40. Third procedure,~~

~~41. Fourth procedure,~~

~~42. Fifth procedure,~~

~~43. Sixth procedure, and~~

~~44. Newborn birth weight.~~

~~**D.** Hospitals shall provide the information required in subsection (C) to the Department in the following format:~~

~~1. Medium - Untitled, 9 track, 1/2 inch tape~~

~~2. Bits per inch - 6250~~

~~3. Record length - 694 characters~~

~~4. Blocksize - 27760 characters~~

~~5. Data format - Extended Binary Coded Decimal Interchange Code~~

~~**E.** The Director shall approve an exception to the format described in subsection (D) in accordance with the following:~~

~~1. A hospital shall submit a written request to use an alternate format 90 days prior to the next due date.~~

~~2. The alternate format shall include:~~

~~a. Name of the software program that the data is to be submitted in, and~~

~~b. A written description of the file layout.~~

~~3. The request shall include a test sample of discharge information as specified in subsection (C).~~

~~4. The Department shall notify the hospital of its decision not less than 60 days prior to the next due date for filing the report.~~

~~**F.** The Director shall revoke, in writing, 120 days prior to the next submission date, an alternate format granted under subsection (E) when the Department determines that it can no longer convert the submitted information into a usable file format.~~

A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department with the inpatient discharge report required in subsection (C):

1. The name of the hospital;
2. The hospital's Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the inpatient discharge report;
4. If the entity submitting the inpatient discharge report to the Department is different from the hospital:
   a. The name of the entity submitting the inpatient discharge report to the Department; and
   b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the inpatient discharge report;
5. The reporting period; and
6. The name of the electronic file containing the inpatient discharge report specified in subsection (C).

B. A hospital administrator or designee shall attest, on a form provided by the Department, that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete.

C. A hospital administrator shall ensure that an inpatient discharge report:

1. Is prepared and named in a format specified by the Department;

2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and
3. Contains the following information for each inpatient discharge that occurred during the reporting period specified in subsection (A)(5):
    a. The Arizona facility ID and national provider identifier for the hospital;
    b. A code indicating that the information submitted about the patient is for an inpatient episode of care;
    c. The patient's medical record number;
    d. The patient's control number;
    e. The patient's name;
    f. The patient's mailing address;
    g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
    h. A code indicating that the patient is homeless, if applicable;
    i. The patient's date of birth and last four digits of the patient's Social Security number;
    j. Codes indicating the patient's gender, race, ethnicity, and marital status;
    k. The date and a code indicating the hour the patient was admitted to the hospital;
    l. A code indicating the priority of visit;
    m. A code indicating the referral source;
    n. The date and a code indicating the hour the patient was discharged from the hospital;
    o. A code indicating the patient's discharge status;
    p. If the patient is a newborn, the patient's birth weight in grams;
    q. Whether the patient has a DNR known to the hospital;
    r. The date the bill for hospital services was created;
    s. The total charges billed for the episode of care;
    t. A code indicating the expected payer source;
    u. For each unit of service billed for the episode of care, the:
        i. Revenue code;
        ii. Charge billed; and
        iii. HIPPS code, if applicable;
    v. The DRG code for the episode of care;

w. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;

x. The International Classification of Diseases codes for the patient's admitting, principal, and secondary diagnoses;

y. If applicable, the E-codes associated with the episode of care;

z. If applicable, the state in which an accident leading to the episode of care occurred;

aa. If applicable, the date of the onset of symptoms leading to the episode of care;

bb. If a procedure was performed during the episode of care:

i. The International Classification of Diseases codes for the principal procedure and any other procedures performed during the episode of care, and

ii. The dates the principal procedure and any other procedures were performed;

cc. The name and national provider identifier of the patient's attending provider;

dd. The name and national provider identifier of the medical practitioner who performed the patient's principal procedure, if applicable; and

ee. The name and national provider identifier of any other medical practitioner associated with the patient's episode of care.

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department twice each calendar year, according to the following schedule:

1. For each inpatient discharge between January 1 and June 30, the reports, information, and attestation statement shall be submitted after June 30 and no later than August 15; and

2. For each inpatient discharge between July 1 and December 31, the reports, information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of a report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.

TABLE 1. ~~MAGNETIC TAPE SUBMISSION – REQUIRED DATA ITEMS AND FORMAT SPECIFICATIONS FOR INPATIENT DISCHARGES~~ Repealed

~~CHARACTERS~~	~~POSITION~~	~~DATA ELEMENT NAME~~	~~UNIFORM BILLING LOCATOR NUMBER~~	~~CODES AND VALUES~~	~~EDIT REQUIREMENTS~~
~~10~~	~~1-10~~	~~Hospital ID - Federal Tax No~~	~~5~~	~~Alpha-Numeric~~	~~All digits must be filled in. Do not change ID without prior permission from DHS.~~
~~17~~	~~11-27~~	~~Patient's Medical Record Number~~	~~23~~	~~Alpha-Numeric~~	~~Must be filled in. Right justified with leading zeros.~~
~~19~~	~~28-46~~	~~Certificate, Social Security Number, or Health Insurance Claim Number~~	~~60~~	~~Alpha-Numeric~~	~~Must be filled in. Right justified~~
~~1~~	~~47~~	~~Patient Race~~	~~-~~	~~Race 1 = American Indian, Aleut, Eskimo 2 = Asian, Pacific Islander 3 = Black 4 = Caucasian, Hispanic 5 = Caucasian, Non Hispanic 6 = Other 9 = Refused~~	~~Must be entered.~~
~~30~~	~~48-77~~	~~Patient Street Address~~	~~13~~	~~Alpha-Numeric~~	~~Must be filled in.~~
~~20~~	~~78-97~~	~~Patient City~~	~~13~~	~~Alpha-Numeric~~	~~Must be filled in.~~
~~2~~	~~98-99~~	~~Patient State~~	~~13~~	~~Alpha-Numeric~~	~~Must be filled in.~~
~~10~~	~~100-109~~	~~Patient's Zip Code~~	~~13~~	~~Alpha-Numeric~~	~~Postal zip code for the patient's residence at the time of admission. If zip plus four is used indicate as XXXXX-YYYY. Must be filled in. If a foreign resident, fill in with name of the country.~~
~~8~~	~~110-117~~	~~Patient's Date of Birth~~	~~14~~	~~Enter month-day-year, without dashes MMDDYYYY~~	~~All digits must be filled in. If any portion of birthday is unknown enter all zeros for the birthday.~~
~~1~~	~~118~~	~~Patient's Sex~~	~~15~~	~~Patient's Sex M = Male F = Female~~	~~Must be filled in.~~
~~8~~	~~119-126~~	~~Date of Admission~~	~~6~~	~~The month, day and year of the patient's admission to the hospital. MM-DD-YY~~	~~All digits must be filled in including dashes.~~
~~8~~	~~127-134~~	~~Date of Discharge~~	~~6~~	~~The month, day and year of the patient's discharge from the hospital. MM-DD-YY~~	~~All digits must be filled in including dashes.~~

2	135-136	Patient's Discharge Status	22	The circumstances under which the patient left the hospital: 01 = Discharged to home or self care. 02 = Discharged/transferred to another short-term general hospital. 03 = Discharged/transferred to skilled nursing (SNF). 04 = Discharged/transferred to an intermediate care facility (ICF). 05 = Discharged/transferred to another type of institution. 06 = Discharged/transferred to home under care of organized home health service organization. 07 = Left against medical advice. 08 = Discharged/transferred to home under care of a Home IV provider. 20 = Expired. 09 = All Other	Must be filled in. Right justified with a leading zero. Zero if unknown.
3	137-139	DRG Code	78	The condition established after study as being chiefly responsible for the admission of a patient to the hospital for care.	All digits must be filled in. Right justified with leading zeros.
7	140-146	Total Charges	47	The total gross charges incurred by the patient. Hospital charges only.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.

~~2~~	~~147-148~~	~~Payer Code~~	~~50~~	~~The expected source of payment for the majority of the charges associated with this treatment.~~ ~~00 = Self pay~~ ~~01 = Commercial (Indemnity)~~ ~~02 = HMO~~ ~~03 = PPO~~ ~~04 = AHCCCS Health Care Group~~ ~~05 = Medicare~~ ~~06 = AHCCCS/Medicaid~~ ~~07 = CHAMPUS/MEDEXCEL~~ ~~08 = Children's Rehabilitation Services~~ ~~09 = Workers' Compensation~~ ~~10 = Indian Health Services~~ ~~11 = Medicare Risk~~ ~~12 = Charity~~ ~~13 = Foreign National~~ ~~14 = Other~~	~~Must be filled in. Right justified with leading zeros.~~

6		Revenue Codes	42	Total gross charges for each revenue code.	All digits must be filled in. Right justified with leading zeros. Note, whole dollars only, rounded.
	149-154	All inclusive rate	10x		
	155-160	Room and board - private	11x		
	161-166	Room and board - two bed	12x		
	167-172	Room and board - 3/4 bed	13x		
	173-178	Private (deluxe)	14x		
	179-184	Room and board - ward	15x		
	185-190	Other room and board Nursery	16x		
	191-196	Intensive Care	17x		
	197-202	Coronary Care	20x		
	203-208	Special charges	21x		
	209-214	Incremental charges	22x		
	215-220	All inclusive ancillary Pharmacy	23x		
	221-226	IV therapy Medical, surgical	24x		
	227-232	supplies	25x		
	233-238	Oncology	26x		
	239-244	DME (other than renal)	27x		
	245-250	Laboratory	28x		
	251-256	Laboratory pathology	29x		
	257-262	Radiology - diagnostic	30x		
	263-268	Radiology - therapeutic	31x		
	269-274	Nuclear Medicine CT scan	32x		
	275-280	Operating room Anesthesia	33x		
	281-286	Blood	34x		
	287-292	Blood Storage/Processing	35x		
	293-298	Other imaging	36x		
	299-304	Respiratory services	37x		
	305-310	Physical therapy	38x		
	311-316	Occupational therapy	39x		
	317-322		40x		
	323-328		41x		
	329-334		42x		
	335-340		43x		

	341-346 347-352 353-358 359-364 365-370 371-376 377-382 383-388 389-394 395-400 401-406 407-412 413-418 419-424 425-430 431-436 437-442 443-448 449-454 455-460 461-466 467-472 473-478 479-484 485-490 491-496 497-502 503-508 509-514 515-520 521-526	Speech therapy Emergency room Pulmonary function Audiology Cardiology Osteopathic services Ambulance Medical social services MRI Med/Surg (Ext. of 27x) Drugs required specific ID Cast room Recovery room Labor / Delivery EKG / ECG EEG Gastrointestinal services Treatment / Observation room Lithotripsy Inpatient renal dialysis Organ acquisition Miscellaneous dialysis Psychiatric treatment Psychiatric services Other diagnostic services Other therapeutic services Professional fees Professional fees Professional fees Patient convenience items All other	44x 45x 46x 47x 48x 53x 54x 56x 61x 62x 63x 70x 71x 72x 73x 74x 75x 76x 79x 80x 81x 88x 90x 91x 92x 94x 96x 97x 98x 99x -		
22	527-548	Physician Name	82	Attending physician's name. Last, First, Middle Initial.	Left justified. Use "unknown physician" if unknown.
6	549-554	Physician State License No.	82	Attending physician's or other practitioner's Arizona License Number.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alpha-numeric (locum tenens).
1	555	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
22	556-577	Other Physician Name	83	Primary procedure physician's name Last, First, Middle Initial.	Left justified. Use "unknown physician" if unknown.
6	578-583	Other Physician State License No.	83	Physician, or other practitioner's Arizona License Number who performed the primary procedure.	All digits must be filled in. Right justified with leading zeros. Fill with zeros if unknown. Can be Alpha-numeric (locum tenens).

1	584	Licensing Board	-	Board: 1 = Medical Examiners 2 = Dental Examiners 3 = Podiatry Examiners 4 = Osteopathic Examiners 5 = Nursing 9 = Other	Must be filled in.
1	585	Type of Admission	19	Indicates the priority (type) of admission: 1 = Emergency 2 = Urgent 3 = Elective 4 = Newborn 9 = Information not available	Must be filled in. If 4 (newborn), **Source of Admission** must be 1-4, or 9 (unknown).
1	586	Source of Admission	20	Indicates the source of admission - adults and pediatrics: 1 = Physician referral 2 = Clinic referral 3 = HMO / AHCCCS health plan referral 4 = Transfer from a hospital 5 = Transfer from a SNF 6 = Transfer from another health care facility (other than acute care or SNF) 7 = Emergency room 8 = Court / Law Enforcement 9 = Information not available If **Type of Admission** = newborn (4) use: 1 = Normal Delivery 2 = Premature Delivery 3 = Sick baby 4 = Extramural birth 9 = Information not available	Must be filled in.
6	587-592	Principal Diagnosis Code	67	Enter the ICD code describing the condition chiefly responsible for causing this hospitalization.	Left adjust. Must be filled in, including decimal and applicable letter, such as V or E code. Leave blank if unknown. If code consists of less than six places, including the decimal, do not zero fill the blank(s) on the right.
6	593-598	Second Diagnosis	68	Enter the ICD code describing additional conditions	Leave blank if not applicable. Otherwise, left adjust, and include decimal and applicable letter such as V or E code. If code consists of less than six places, including the decimal, do not zero fill the blank(s) on the right.
6	599-604	Third Diagnosis Code	69	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.

6	605-610	Fourth Diagnosis Code	70	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	611-616	Fifth Diagnosis Code	71	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	617-622	Sixth Diagnosis Code	72	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	623-628	Seventh Diagnosis Code	73	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	629-634	Eighth Diagnosis Code	74	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	635-640	Ninth Diagnosis Code	75	Same as the second diagnosis code.	Same as instructions for the second diagnosis code.
6	641-646	External Cause of Injury	77	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
6	647-652	Second External Cause of Injury	-	Enter the ICD code describing the external cause of injury.	Leave blank if not applicable. Otherwise, left adjust, include decimal and the letter E.
8	653-660	Principal Procedure Date	80	The month, day, and year of the patient's principal procedure MM-DD-YY	All digits must be filled in including dashes.
5	661-665	Principal Procedure Code	80	Enter the ICD code that identifies the principal procedure performed.	Left adjust. Must be filled in, including decimal. Leave blank if unknown. If code consists of less than five places, including the decimal, do not zero fill the blank(s) on the right.
5	666-670	Second Procedure Code	81A	Enter the ICD code describing procedures other than the principal procedure.	Leave blank if not applicable. Otherwise left adjust and include decimal. If code consists of less than five places including the decimal, do not zero fill the blank(s) on the right.
5	671-675	Third Procedure Code	81B	Same as second procedure code.	Same as instructions for the second procedure code.
5	676-680	Fourth Procedure Code	81C	Same as second procedure code.	Same as second procedure code.
5	681-685	Fifth Procedure Code	81D	Same as second procedure code.	Same as second procedure code.
5	686-690	Sixth Procedure Code	81E	Same as second procedure code.	Same as second procedure code.
4	691-694	Newborn Birth Weight	-	Birth weight in grams.	Must be entered for all newborns.
Data Requirements for Reporting Under A.R.S. 36-125.05: MEDIUM: 9 TRACK, 1/2 INCH TAPE BPI: 6250 RECL: 694 CHARACTERS					

~~BLOCKSIZE: 27,760 LABEL: NO LABELS DATA FORMAT: EBCDIC~~ ~~MAGTAPE.FN2 (2/2/95)~~					

ARTICLE 5. ~~OUTPATIENT SERVICES~~ EMERGENCY DEPARTMENT DISCHARGE REPORTING

R9-11-501. Definitions

~~The following definitions apply in this Article:~~

~~1. "Charge" means the same as "rate or charge" in R9-11-101.~~

~~2. "Diagnosis" means a determination of an individual's disease, illness, or injury, made by a health care provider authorized by law to make the determination.~~

~~3. "Diagnostic-related group code" means a numeric or alpha-numeric identifier that is assigned by the Center for Medicare and Medicaid Services to two or more outpatient services that are provided to an individual with a specific diagnosis.~~

~~4. "Governing authority" has the same meaning as in A.R.S. § 36-401.~~

~~5. "Hospital" has the same meaning as in A.A.C. R9-10-201.~~

~~6. "Hospital identification number" has the same meaning as in R9-11-401.~~

~~7. "Outpatient" has the same meaning as in A.A.C. R9-10-201.~~

~~8. "Outpatient services" means:~~

~~a. Hospital services as defined in A.A.C. R9-10-201 provided to an outpatient by a hospital; and~~

~~b. Outpatient surgical services as defined in A.A.C. R9-10-1701 provided to an individual by an outpatient surgical center.~~

~~9. "Outpatient surgical center" has the same meaning as in A.R.S. § 36-401.~~

~~10. "Patient certificate or social security number" has the same meaning as "patient certificate/social security number" in R9-11-401.~~

~~11. "Patient control number" has the same meaning as in R9-11-401.~~

~~12. "Payer code" has the same meaning as in R9-11-401.~~

~~13. "Procedure" means a surgical operation or technique.~~

~~14. "Tax ID number" means the numeric identifier that a person uses to report financial information to the United States Internal Revenue Service.~~

~~15. "Total patient charges" has the same meaning as in R9-11-401.~~

In this Article, unless otherwise specified:

1. "CPT code" means a code from Current Procedural Terminology, a HCPCS coding system used primarily to identify medical services and procedures provided by medical practitioners.
2. "Emergency department discharge report" means a document that meets the requirements of A.R.S. § 36-125.05 and contains the information required in R9-11-502.
3. "HCPCS" means the Healthcare Common Procedure Coding System used by a hospital for billing for hospital services or commodities provided to an outpatient as defined in A.A.C. R9-10-201.

R9-11-502. Reporting Requirements

~~A governing authority of a hospital or an outpatient surgical center shall submit the following information for each outpatient according to the schedule and format requirements in R9-11-402:~~

~~1. An identification number as follows:~~
   ~~a. For a hospital, the hospital identification number; or~~
   ~~b. For an outpatient surgical center, the outpatient surgical center's tax ID number;~~
~~2. The patient control number;~~
~~3. The patient certificate or social security number;~~
~~4. The patient's address including city, state, and zip code;~~
~~5. The patient's date of birth;~~
~~6. The patient's sex;~~
~~7. The date outpatient services were initiated;~~
~~8. The date outpatient services were terminated;~~
~~9. The diagnostic related group code;~~
~~10. The total patient charges;~~
~~11. The payer code;~~
~~12. The principal diagnosis;~~
~~13. The second diagnosis;~~
~~14. The third diagnosis;~~
~~15. The fourth diagnosis;~~
~~16. The fifth diagnosis;~~
~~17. The sixth diagnosis;~~
~~18. The seventh diagnosis;~~
~~19. The eighth diagnosis;~~

~~20. The ninth diagnosis;~~

~~21. External cause of injury;~~

~~22. Second external cause of injury;~~

~~23. The date of the principal procedure;~~

~~24. The principal procedure;~~

~~25. The second procedure;~~

~~26. The third procedure;~~

~~27. The fourth procedure;~~

~~28. The fifth procedure; and~~

~~29. The sixth procedure.~~

A. A hospital administrator shall ensure that the following information, in a format specified by the Department, is submitted to the Department as part of the emergency department discharge report required in subsection (C):

1. The name of the hospital;
2. The hospital's Arizona facility ID and national provider identifier;
3. The name, mailing address, telephone number, and e-mail address of the individual at the hospital whom the Department may contact about the emergency department discharge report;
4. If the entity submitting the emergency department discharge report to the Department is different from the hospital:
    a. The name of the entity submitting the emergency department discharge report to the Department; and
    b. The name, mailing address, telephone number, and e-mail address of the individual at the entity specified in subsection (A)(4)(a) who prepared the emergency department discharge report;
5. The reporting period; and
6. The name of the electronic file containing the emergency department discharge report specified in subsection (C).

B. A hospital administrator or designee shall attest, on a form provided by the Department, that, to the best of the knowledge and belief of the hospital administrator or designee, the information submitted according to subsection (C) is accurate and complete.

C. A hospital administrator shall ensure that an emergency department discharge report:

1. Is prepared and named in a format specified by the Department;

2. Uses codes and a coding format specified by the Department for data items specified in subsection (C)(3) that require codes; and
3. Contains the following information for each emergency department discharge that occurred during the reporting period specified in subsection (A)(5):
    a. The Arizona facility ID and national provider identifier for the hospital;
    b. A code indicating that the information submitted about the patient is for an emergency department episode of care;
    c. The patient's medical record number;
    d. The patient's control number;
    e. The patient's name;
    f. The patient's mailing address;
    g. If the patient is not a resident of the United States, a code indicating the country in which the patient resides;
    h. A code indicating that the patient is homeless, if applicable;
    i. The patient's date of birth and last four digits of the patient's Social Security number;
    j. Codes indicating the patient's gender, race, ethnicity, and marital status;
    k. The date and a code indicating the hour the episode of care began;
    l. A code indicating the priority of visit;
    m. A code indicating the referral source;
    n. The date and a code indicating the hour the patient was discharged from the emergency department;
    o. A code indicating the patient's discharge status;
    p. Whether the patient has a DNR known to the hospital;
    q. The date the patient's bill was created;
    r. The total charges billed for the episode of care;
    s. A code indicating the expected payer source;
    t. For each unit of service billed for the episode of care, the:
        i. Revenue code;
        ii. Charge billed; and
        iii. HCPCS code, if applicable;
    u. The code designating the version of the set of International Classification of Diseases codes used to prepare the bill for the episode of care;

v. The International Classification of Diseases code designating the reason for the patient initiating the episode of care;

w. The International Classification of Diseases codes for the patient's principal and, if applicable, secondary diagnoses;

x. If applicable, the E-codes associated with the episode of care;

y. If applicable, the state in which an accident leading to the episode of care occurred;

z. If applicable, the date of the onset of symptoms leading to the episode of care;

aa. For each procedure performed during the episode of care:

i. The applicable International Classification of Diseases, HCPCS/CPT codes for the principal procedure and any other procedures performed during the episode of care; and

ii. The dates the principal procedure and any other procedures were performed;

bb. The name and national provider identifier of the patient's attending provider;

cc. The name and national provider identifier of the medical practitioner who performed the patient's principal procedure, if applicable; and

dd. The name and national provider identifier of any other medical practitioner associated with the patient's episode of care.

D. A hospital administrator shall ensure that the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) are submitted to the Department twice each calendar year, according to the following schedule:

1. For each emergency department discharge between January 1 and June 30, the report, information, and attestation statement shall be submitted after June 30 and no later than August 15; and

2. For each emergency department discharge between July 1 and December 31, the report, information, and attestation statement shall be submitted after December 31 and no later than February 15.

E. A hospital administrator who receives a request from the Department for revision of an emergency department discharge report not prepared according to subsections (A), (B), and (C) shall ensure that the revised report is submitted to the Department:

1. Within 21 calendar days after the date on the Department's letter requesting an initial revision, and

2. Within seven calendar days after the date on the Department's letter requesting a second revision.

F. If a hospital administrator or designee does not submit the report specified in subsection (C), the information specified in subsection (A), and the attestation statement specified in subsection (B) according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.